DENTISTRY
For Children and Families
Creating Smiles for a Lifetime

Welcome! Thank you for choosing Dentistry For Children and Families. It is our goal to provide you with the best possible dental care. To help us meet all of your possible dental health needs, please fill out this form. If you have any questions, please ask.

Patient Information (Confidential)

Name _____ Preferred Name _____ Birthdate_____
Gender: Male ☐ Female ☐ Home Phone (____)_____ Cell Phone (____)_____
Email _____ Social Security # _____
Address_____ City_____ State_____ Zip_____
Status: Minor ☐ Single ☐ Married ☐ Name of Spouse_____ Divorced ☐ Widowed ☐ Separated ☐
If patient is a full time student, Name of School_____ State_____
Name of Employer_____ Work Phone(____)_____
Address of Employer_____ City_____ State_____ Zip_____
Do you currently have an account with Dentistry For Children And Families? Yes ☐ No ☐
Are any other family members patients of ours? No ☐ Yes ☐ Please List_____
How do you plan to take care of this account? Cash/Check ☐ Credit Card ☐ Wish to Discuss Payment Options ☐
Whom may we thank for referring you? _____
Nearest relative or friend not living with you whom we can call in an emergency_____
Relationship_____ Phone (____)_____

Insurance Information

Name of insured_____Relationship to patient _____
Birthdate: _____Social Security #_____Date Employed_____
Name of Employer_____ Work Phone (____)_____
Address of Employer_____ City_____ State_____ Zip_____
Insurance Company_____ Group#_____ Union or Local#_____
Insurance Company Address_____City_____ State_____ Zip_____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand I am required to take care of any portion not expected to be paid by insurance at the time of treatment. If my dental insurance carrier pays less than expected, I understand any remaining balance is my responsibility and I agree to be responsible for payment of all services rendered on my behalf and my dependents. If Denistry For Children And Families seeks enforcement of payment through the services of a collection agency, I shall be responsible for any incidental expenses, including collection costs/attorney fees.

Date_____ Patient/Parent Signature_____Received By_____

Medical History

Physician's Name_____Date of Last Physical_ _____
Have you had any of the following?

____ AIDS (or other immunosuppressive disorders)
____ Allergies
____to medications/drugs
____anesthetics
____gernal allergies
____Circulatory/Heart Problems
____artificial heart valves
____Cancer
____Digestive/Eating Disorders
____ High Blood Pressure
____low blood pressure
____hemophilia
____blood disease
____stroke
____mitral valve prolapse
____heart murmur
____Chemical Dependency
____Ulcer
____Venereal Disease
____ Epilespsy
____Hepatitis
____Headaches
____Radiation Therapy
____Psychiatric Conditions
____Respiratory Disease
____Asthma
____Rheumatic Fever
____Sinus Problems
____Diabetes